

Barriers and Facilitators to Implementing Shared Decision-Making in Critical Care: A Qualitative Study of Lebanese Health Service Delivery

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Research Article

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Abstract

Background

Heart failure patients on mechanical circulatory support are often the target of difficult critical discussion. Shared decision making plays an essential role in ensuring high quality patient-centered care, yet systemic barriers persist. The aim of this research was to explore, utilizing nurses as a frontline healthcare workforce, the organizational, communicative, and infrastructural challenges of shared decision-making within intensive care units in Lebanon..

Method

A qualitative descriptive research design informed by descriptive phenomenology was employed. In-depth interviews were carried out among 20 critical care nurses at three different hospitals in Beirut. Inductive thematic analysis was conducted over the period of 2 months.

Results

The inductive thematic analysis generated two main themes and six subthemes. The first theme was titled, "Challenges faced by patients in SDM" which included "Life or death decisions in face of ambiguity", "Strained relationships and communication", and "Struggle of discharge" as subthemes. The second theme was titled, "Role of nurses in SDM", which had "Circumstantial analysis", "Advocating for patients", and "Collaborative design of care" as subthemes.

Conclusion

In addition to highlighting the inherent challenges of navigating sophisticated medical care, the study also underscores the vital role that critical care nurses play in promoting shared decision making among heart failure patients in Lebanon. The findings also highlights the importance of better hospital communication and discharge planning.

Background

Due to the increasing risk factors for chronic illnesses, the amount of patients in Lebanon developing heart failure and needing the relevant care has grown [1]. Heart failure is a complex medical condition characterized by the inability of the heart to pump blood efficiently, resulting in insufficient oxygen and nutrients being delivered to the body's tissues. It is a progressive condition that can be caused by various factors, including underlying heart diseases, such as coronary artery disease, hypertension, or previous heart attacks [2]. Diagnosis and classification of heart failure depends on a range of signs and symptoms detected upon medical examination, as well as diagnostic tests such as echocardiography,

electrocardiogram, biomarkers, and cardiac imaging [3]. The difficulties associated with heart failure are becoming more widely acknowledged worldwide, where this condition often requires intensive care management [4]. The ICU serves as a crucial setting for the treatment and care of heart failure patients, where decisions about treatment options, interventions, and end-of-life care are frequently encountered. Technological advancements in medicine have broadened the variety of treatments available, extended the course of the illness, and sustained life [5]. For instance, advanced heart failure patients frequently need aggressive invasive procedures, and cutting-edge treatments, even life-sustaining ones. In situations of abrupt distress-induced cardiac shock, several forms of mechanical circulatory support (MCS) are currently being employed more often for short-term enhancement of circulation. Nevertheless, there isn't much solid proof to support their use [6].

While MCS has the potential to save lives in the short term, moral questions about how long it should be used to preserve life persist [7]. For instance, installation of a left ventricular assist device (LVAD) may be a viable choice as an interim solution to cardiac transplant or as endpoint therapy for those with severe heart failure who have had a progressive decline in their condition or for those who have survived a cardiogenic shock [8]. But after having an implanted LVAD, these patients are more likely to have unfavorable consequences that can significantly and negatively impact their well-being and quality of life, increasing the need for treatment [9].

Thus, these advancements have created more complex decisions to be made on the part of both healthcare providers and patients, as well as their families. As a result, system changes in the provision of healthcare are necessary [10]. Decisions regarding treatment now need to be made through a shared decision-making (SDM) approach that takes into account the opinions of patients as well as medical professionals [11]. However, it is becoming more difficult to make shared decisions, particularly when patients have acute heart failure and their lives are threatened. Therefore, it is necessary to define the best SDM practices in these contexts [12].

Shared decision making (SDM) is a paradigm that was first created to support the relationship between patients and physicians and places a strong emphasis on patient engagement. However, given that patients make decisions in complicated real-world settings with the involvement of several persons, a larger notion of SDM has been developed [13]. Thus, interprofessional SDM models (IP-SDM), which include a team-based method for SDM in the critical care domain, have been established to stress the engagement of healthcare workers from various disciplines [14]. However, the specific functions that nurses play in the IP-SDM method are yet not fully established. Although staff nurses did not have complete involvement in shared decision-making (SDM), they provided autonomous nursing assistance that supported IP-SDM activities, leading to a systematic implementation of SDM involving patients, families, and medical providers [15]. Thus, in this context it is not quite clear how the nurse contributed to the process of IP-SDM. Considering that in critical care contexts, nurses play a crucial role in various facets of the patients' care, the involvement of critical care nurses in shared decision-making processes especially in life-threatening situations becomes pivotal, as possess valuable insights into patient needs, preferences, and care outcomes [16, 17].

While shared decision making has gained recognition as an essential element of patient-centered care, limited research has explored the specific perspectives of critical care nurses in the ICU regarding this collaborative process, particularly in the context of heart failure care [18]. It could be possible to devise new methods for handling complicated SDM for challenging judgments and crucial timing if nurses' distinct responsibilities in decision-making assistance are well understood [19]. In Lebanon, most medical and health-related university programs include an interprofessional education course, which introduces students to the concepts of IP-SDM, however its implementation in policy and practice in clinical settings is still under-researched. Thus, it is vital to investigate the nursing perspective regarding the delivery of shared decision-making and to elucidate the nurses' viewpoints of patient challenges, particularly for those who need multifaceted treatment decisions, in order to establish the distinctive inputs and functions of nursing staff in SDM beyond acting as intermediaries. In order to reconsider the special position that nurses play in the establishment of interdisciplinary healthcare structures, the American Association of Critical Care Nurses established the synergy model for patient care, which places a strong emphasis on the patient-nurse interaction. The goal of this synergy model is to maximize results by associating particular patient attributes with particular nursing abilities. This synergy model's patient-nurse connection may serve as an illustration for creating a special nursing position that would assist patients with SDM [20]. Thus, after reviewing the relevant literature and using the synergy model as a conceptual framework, we intend to explore the critical care nurses' perspectives on the challenging circumstances that patients with heart failure encounter and evaluate institutional barriers to operationalizing shared decision making.

Methods

Research design

The current study's qualitative design was descriptive in nature. It's a way of putting phenomena into simple language. The study was informed by the principles of Husserlian descriptive phenomenology due to the flexibility of the qualitative research framework [21]. As a result, constructivism provides the epistemic framework for the study, in which several realities are considered and participants' perspectives are investigated via their social interactions with their context [22]. A qualitative descriptive technique seeks to precisely describe occurrences and the ways in which participants understand those experiences [23]. The goal is to present data that explains the where, what, and who of events or occurrences that are being investigated. Because of this, it is evident that this approach relates to questions that seek to convey accurate perceptions of the subject or subjects without reference to a more in-depth justification or motive [24]. The present study aimed to delineate how nurses' experiences shaped their opinions and beliefs about shared decision making with patients suffering from heart failure. The Consolidated Criteria For Reporting Qualitative Research (COREQ) standards were followed in the production of this paper.

Participants

Twenty critical care nurses who serve at two private university hospitals and one governmental hospital in Beirut, the capital of Lebanon, participated in this study. These nurses were purposively selected to have at least two years of experience working in critical care units and caring for heart failure patients. This selection criteria enabled capturing the perceptions of nurses based on their expertise on the topic being studied. It was vital to include nurses from governmental and private institutions in order to fully capture the subtle variations in perceptions that context may allow in regards to shared decision making among heart failure patients.

Settings

The governmental hospital that served as the recruitment site is a general hospital that offers advanced tertiary treatment in several disciplines. It is a teaching hospital that trains future doctors and nurses via academic affiliations with several universities. Its objective to do research, promote initiatives that advance the development of medical knowledge, and provide patients with comprehensive care is stated in its policy. As a result, it serves patients from all across the nation and from various socioeconomic backgrounds, making it a national hospital. For inhabitants of Beirut and the neighboring areas, the hospital has served as the primary healthcare facility. Prior to this, healthcare was supplied by government bureaucracy as a method of providing treatment. Since the two private hospitals were both university hospitals, they fostered an environment that encouraged scholarly research and provided training opportunities for students. Patients with a variety of medical problems and demographics are also drawn to these two facilities. Modern medical technology and equipment are available in these facilities to deliver top-notch diagnosis, treatments, and interventions. These two hospitals are accredited by renowned quality assurance agencies and are designated to be centered around elevating patient experience through advanced nursing services. It is noteworthy to mention that a referral pathway has been established between the three hospitals to provide severe heart failure patients with mechanical circulatory support services such as an LVAD.

Sampling

The study utilized a purposive sample approach to choose proficient critical care nurses from the multiple hospitals located in Beirut, Lebanon. The sampling period extended from November 2023-January 2024. The nurses were chosen on the basis of their background in providing mechanical circulatory support and in caring for patients with heart failure. As a result, nurses employed in telemetry units, cardiac surgical units, intensive care units, and cardiac care units were purposefully chosen by the investigators. To attempt to capture the diverse opinions of the nurses in these different wards, maximum variation sampling was used. This made it possible to comprehend the phenomenon at hand more thoroughly. We were also capable of including nurses with a range of professional responsibilities (RNs and Charge Nurses), years of experience, ages, and gender identities because of maximum variation sampling. However, the inclusion criteria made it clear that the nurses needed to have worked in those particular units for at least two years in order to be included in the present investigation.

Recruitment and data collection

A total of 26 nurses received a request to participate, and 20 of them accepted, resulting in a response rate of 76.92%. Specific reasons for rejection were not formally tracked but heavily attributed to heavy workloads. The invitation letter was written in a clear and succinct manner, outlining the significance and goal of the study, along with the possible advantages and relevance of the research for the participants, which ensured a high response rate. The study team sent the invitation to the nurses individually, and they were invited in a kind yet professional manner. This lessened the possibility of a power imbalance and any subsequent coercive aspect influencing the nurses' decision to provide their consent. Additionally, the investigators made clear the time commitment that was anticipated of participants and the confidentiality and anonymity of the interviews. This lessened uncertainty and participation obstacles. Furthermore, the investigators employed several modes of contact to connect with possible respondents. Emails, phone conversations, social media posts, and face-to-face meetings all fell under this category. Lastly, the investigators made sure to give the nurses contact information so they could ask any questions and promptly reminded those who had not yet replied. A written informed consent form was completed by nurses who indicated interest in participating, and a convenient, private one-on-one interview was scheduled. Data collection continued until no new themes emerged after consecutive interviews. The period of data collection was January 2024–February 2024.

Interviews

The principal researcher conducted in-depth interviews; the interviewer is a female who has a Ph.D. in nursing. She was a research assistant at the time of the study. The interviewer and participants have never met before the original invite to participate. The interviewer has received training in qualitative research methods and investigation. It was stated to the participants that the study was pursued for academic and publications purposes. To ensure the respondents' ease, the interviews were performed in each nurse's naturalistic environment according to their own timetables. The interviewer employed reflexivity, wore appropriate clothing in a way that is respectful for the nurses culture and not intimidating for them. The interviewer avoided making any presumptions throughout the interviews, where any assumptions were actively bracketed and noted down in field notes. There were no non-participants in the room during the interviews. Each interview lasted between forty-five minutes and an hour, during which the interviewer spoke alone with the critical care nurses to ensure they felt comfortable sharing their experiences and opinions in full. The interviewer reiterated the main goal of the conversation after breaking the ice. She confirmed consent for the meetings to be audio recorded and gave the respondents her assurance that the discussions would remain private and anonymous. Field notes were obtained during the interviews to document any contextual information and nonverbal indications that may be relevant to the investigation. It was decided to employ an interview guide based on Krueger and Casey [25], which contained introductory, transitional, and key questions. The interview guide is provided in Supplementary File 1. The interview guide was not pilot tested. The nurses received closing prompts at the conclusion of the interview, along with additional questions if required. To ensure consistency, each nurse was asked the identical questions (Table 1). No repeat interviews were done.

Table 1
Interview Questions

Introduction Question	What are your thoughts on the phrase "shared decision making"?
Transition Question	How do you describe your experiences caring for heart failure patients?
Key Questions	What do you think about shared decision making among heart failure patients?
	What do you think about shared decision making among heart failure patients on mechanical circulatory support?
	What are the challenges that these patients face in shared decision making?
	What do you think is the nurses' role in shared decision making with patients suffering from severe heart failure?
Final prompt	Do you have anything further to say ?
Probing Questions	Could you give us a better description?
	Could you provide us with a better description?

Data Analysis

The interviewer, who was also the primary investigator, carefully transcribed the interviews after listening to the audio tapes several times. Transcripts were not returned to the applicant for comments. Pseudonyms were used to safely disguise the respondents' identities; as a result, both explicit and implicit identifiers were eliminated from the transcripts. Due to the Arabic language used during the interviews, two sworn translators received the printed transcripts and translated them both ways. Subsequently, the transcripts were forwarded to an additional specialist in order to assess the accuracy of the translation. The study team was then tasked with analyzing the transcripts. The approach followed the seven steps of inductive thematic analysis: reviewing the transcripts, coding important phrases, creating meanings, grouping and thematic structuring, giving thorough descriptions, and cross-checking the results with the participating nurses. To challenge the team members' presumptions and support the data-driven conclusions, analyst triangulation was used. Each team member coded individually after thoroughly studying the data to uncover certain key themes. The three then got together, spoke over the results, and worked out any differences. To make sure that the investigators fully understood the nurses' points of view, the transcripts were gone over many times. After that, a representative statement emphasizing the true significance of the information presented was added to each quotation. Following the categorization, rearrangement, and amalgamation of these terms into qualitative themes, the investigators scrutinized the themes to ascertain their precision in depicting the phenomenon under study. The process of data analysis was done manually.

Trustworthiness and credibility

To guarantee the rigor of the results, the five-step trustworthiness criteria—credibility, dependability, confirmability, transferability, and authenticity—established by Guba and Lincoln [26] were applied. By using member-checking, the findings' credibility was enhanced. By making the developed themes and descriptions available to individuals who participated, we were able to ascertain whether or not they still accurately reflected the viewpoints of the participants. Having many coders involved in the data analysis process increased the trustworthiness of the results. This countered the researchers' presumptions and demonstrated that the respondents' testimonies backed the findings. Dependability and confirmability were increased by creating an audit trail from the raw data and field notes, which comprised observations, perceptions, comments, process notes, and the underlying presumptions of analytical inferences. Delineating the features of the sample and providing thorough explanations of the participant viewpoints enhanced transferability. In addition to the thorough justifications, the inclusion of participant quotations in the findings facilitates an accurate and fair representation of the range of individual viewpoints. The value of giving participants a voice, fostering unique viewpoints, and inspiring action through the sharing of research findings is emphasized by the principle of authenticity. The results of this study raise awareness of the significance of shared decision making and the role of nurses with heart failure patients. This is thought to encourage discussion and consequent action to support more research in this area.

Ethical Considerations

Rayak hospital provided clearance to conduct the study and Institutional Review Board approval (IRB number: ECO-R-219). After receiving assurances that participation in the research is entirely voluntary and that choosing not to participate would have no detrimental effects, each volunteer gave written consent. The nurses were also informed on many occasions that their involvement would be kept confidential and that no personally identifying information would be used in any public materials. Each respondent was assigned a pseudonym in order to preserve their privacy, and the recorded responses were encrypted and anonymized. The study team was the only ones with access to the password-protected folder containing the transcriptions and recordings.

Results

Characteristics of the respondents

The sample of the study consisted of 20 nurses in total, where 11 (55%) were male, while 9 (45%) were females. The sample was also distributed between private and governmental hospitals, where 12 (60%) worked at private hospitals and 8 (40%) worked at the governmental hospital. The average age of the participants was 34.54 ± 2.3 years, and the average years of experience was 6.7 ± 1.3 .

Qualitative findings

The inductive thematic analysis generated two main themes and six subthemes as shown in Table 2.

Table 2
Thematic Tree

Themes	Subthemes
Challenges faced by patients in SDM	Life or death decisions in face of ambiguity
	Strained relationships and communication
	Struggle of discharge
Role of nurses in SDM	Circumstantial analysis
	Advocating for patients
	Collaborative design of care

Challenges faced by patients in SDM

Life or death decisions in face of ambiguity

The critical care nurses participating in this study indicated that patients often find themselves in situations where they must make crucial choices about treatment options, interventions, or end-of-life care, despite facing a lack of clear-cut answers or prognoses. The nurses highlighted how patients grapple with the uncertainty of their prognosis, the potential risks and benefits of different treatment options, and the ambiguity surrounding the long-term outcomes of their choices. For instance, one of the nurses said, “...It's truly heartbreaking to witness the immense burden that patients and their families carry when faced with life or death decisions... we are with patients at one of the most overwhelming and ambiguous crossroads imaginable. If there's little consensus as to what the “correct” course of action actually is, we find ourselves trying to help patients feel guided and supported – while also allowing them to make the deeply personal, life-changing decisions that are right for them. We understand that such decisions are rarely clear cut and often have massive implications for the rest of their lives...” (N11). Another nurse also shared a similar account, “...The implications attached to these life and death decisions are twisted even further by their inherent ambiguity. There's so much information, so many opposing opinions, and so little about any of it that is entirely predictable. It's extremely tough for patients to make a well-informed decision when there are no guarantees and no “do it and watch for A, B, then C and you'll survive”-style instructions to follow...” (N2). During the interviews, the nurses also discussed the ambiguity as limiting patients' ability to actively participate in shared decision making. For example, one of the shared accounts was, “...the emotional and ethical challenge patients face when making these decisions is not the easiest thing to witness. We as critical care nurses, often find ourselves asking the same questions as the patients... The weight of these choices and the profound impact it will have on our patients is not lost on us either...” (N9). Another nurse also said, “...the inherently ambivalent nature of life or death decisions can create a significant emotional burden for patients. Patients experience overwhelming anxiety, fear and distress, posing formidable obstacles to their ability to engage in shared decision-making....” (N20).

Strained relationships and communication

The nurses articulated how the patients' strained relationships with both their families and healthcare providers affect their ability to actively participate in decision making and the complexities that arise from conflicting perspectives and communication breakdowns. Patients may experience pressure, guilt, or conflicts arising from differing viewpoints on treatment options, values, or cultural beliefs. These strained relationships can create additional stress and emotional turmoil for patients, potentially clouding their ability to make decisions that align with their own wishes and values. For instance, one of the nurses said, "...the relationships between families, healthcare professionals, and LVAD patients become tense sometimes and can create emotional turmoil and conflicting perspectives on the use of mechanical circulatory support..." (N3). Another nurse proclaimed, "...I remember a case where the family had reservations about the use of an LVAD for their loved one... the family and healthcare team had conflicting opinions, leading to strained relationships...there was clear need for proper communication and emotional support..." (N18). Nurses also reflected on difficulties in communication that stem from the strain related to relationships. Patients may have difficulties expressing their thoughts, concerns and preferences openly, fearing judgment and conflicting reactions from both sides. This can result in a profound sense of isolation, frustration and confusion for patients as they attempt to navigate the complexity of inconsistencies of conflicting perspectives. For example, one of the nurses said, "...I noticed that my patient struggled to effectively communicate her thoughts and concerns... she was quite silent...She feared judgment and conflicting reactions from both sides... we had long conversations where I actively listened, providing reassurance and validation. Gradually, she began to find her voice amidst the noise..." (N5).

Struggle of discharge

The nurses further elaborated on the challenges when the patient is discharged to the community. For LVAD patients, the device acts as a lifeline, providing mechanical support to a weakened heart. While LVAD offers the promise of extended life and improved quality of life, the transition from the hospital to the community poses significant hurdles. Severely ill patients often require ongoing medical attention and specialized care, making it difficult to receive adequate support in a community setting. For example, one of the nurses said, "...these patients face the daunting task of managing their condition at home, which often requires a delicate balance between medical care and everyday activities. Our role is to empower them with the knowledge and skills needed for self-care, while also connecting them with the appropriate resources and support systems..." (N7). Another nurse also said, "...we understand the complexities they encounter, from finding suitable healthcare providers to managing device-related complications and maintaining a safe living environment. It is our responsibility to advocate for these patients ... we can help ease the struggle of discharge and empower LVAD patients to live their lives to the fullest while managing their condition..." (N12).

Role of nurses in SDM

Circumstantial analysis

The participating nurses emphasized the critical responsibility of nurses in thoroughly analyzing the situation, initiating discussions based on comprehensive assessments, and ensuring that the decision-making process is based on all relevant factors. Nurses play a vital role in analyzing the situation from a holistic perspective. They consider not only the patient's medical condition but also their socio-economic background, cultural beliefs, emotional well-being, and personal preferences. By taking into account all these comprehensive factors, nurses provide a more complete understanding of the patient's circumstances. For instance, one of the nurses said, "...we understand the importance of considering all the different aspects of a person's situation when making decisions together. We take the time to listen to our patients, understand their needs, and gather all the information necessary to make informed choices. Our goal is to ensure that the decisions we make are based on what's best for the individual as a whole..." (N15). Another nurse also proclaimed, "...we believe in working collaboratively with our patients, their families, and the healthcare team to consider all the factors that might impact their care. By analyzing the situation together, we can make decisions that consider their medical condition, lifestyle, and personal preferences, ultimately leading to better outcomes and a patient-centered approach..." (N4).

Fighting for patient rights

Nurses in this study also honed in on an essential role of the nurse in advocating for the rights of those severely affected by heart failure, as well as supporting the autonomy of these patients as they make decisions. They may face complex medical situations and may need support to navigate their values and preferences and related treatment options. For instance, one of the nurses said, "...as nurses, we advocate and advocate for patients. Therefore, we ensure disclosure of relevant information, and ensure that they have a say in their choices and decisions. Thus, I think that they should be in the center of the driven nursing care, to have a sense of control, and to know all the options they have. People feel free when they have all the information needed to choose..." (N16). Another nurse also said, "...We're there to support them and make sure their voices are heard. We want them to feel comfortable speaking up and sharing what they want for their care..." (N9). A further account was, "...We want to make sure they don't feel alone in their journey. We provide them with the knowledge and support they need to make choices that align with their values. It's about being their advocate and ensuring that their rights are respected, so they can have the best possible outcome..." (N17).

Collaborative design of care

Left Ventricular Assist Device (LVAD) patients face many challenges such as the need for specialized medical care, changes to their daily lives, emotional and psychological adjustments and more. Faced all at once, they can be overwhelming. Their broad understanding of patient needs and their expertise in care coordination puts nurses in an ideal position to lead collaborative efforts in designing care to meet these challenges. Nurses support collaborative efforts by fostering open, empathetic communication and incorporating patients and families into decision processes. Courting "advice" from patients and families within the context of their values, preferences and unique life circumstances enables nurses to

co-create care approaches that enable patients to assume a more active role in their care and make better-informed decisions. For instance, one of the nurses said, "...working together and thinking creatively is the most powerful way to provide the best care for LVAD patients. We listen to patients' needs and collaborate with each other, as well as other healthcare professionals, so that we can create care plans that are in harmony with their values and preferences. By combining the knowledge that has worked in the past with new ideas, we are able to help patients overcome challenges and improve their overall well-being..." (N17). Another nurse also had a similar account, "...we understand the importance of teamwork and thinking outside the box. By working together with patients and the healthcare team, we create care plans that match their values and preferences. We're always looking for fresh ideas and ways to overcome obstacles, so our patients can live their lives the way they want..." (N1).

Discussion

The present investigation centered on the interaction between patients and nurses in shared decision making contexts when treatment decisions were being made with patients with advanced heart failure. The in-depth interviews with critical care nurses in Lebanon resulted in two main themes and six subthemes that focused on the main challenges that are faced by heart failure patients in navigating treatment choices as well as the nurse' roles and functions that they could fulfill in the context of shared decision making within a healthcare team. The essence of the qualitative results highlight the value of the nursing workforce in critical care areas for the success of shared decision making processes and thus better clinical outcomes for the patients.

When it came to making choices about care, individuals who had advanced heart failure experienced challenges that the critical care nurses who conducted the interview articulated and documented. This research also showed that critical care nurses performed a variety of interactive functions among the nursing team, including overall care coordination and manage care through patient-family relationships, based on the patient's challenges. The patient-physician tandem has been the emphasis of SDM in medical choices in previous research; nevertheless, the results of this study showed how important critical care nurses' distinct and varied responsibilities are in advancing SDM. This is in line with previous research that shows that nurses were professionally alienated in this type of context [27]. Also, the challenging decision-making circumstances that these patients with advanced heart failure faced are similar to those that have been documented in previous research [28–30].

Similar to our findings, several studies have shown difficulties with mechanical circulatory support decisions among individuals with advanced heart failure, such as the need to make a choice between life and death, surrogate decision-making, and intense time constraints [31, 32]. Moreover, individuals who suffer from advanced heart failure still struggle to cope with their condition due to hopelessness and fear, even if they are able to express what they believe and think [33, 34]. These can make it difficult to participate in making choices, as our study showed. Not only patients but also nurses struggled with the challenges of caring for terminally ill patients and with the experience of moral judgments in intensive

care units according to various recent studies in Iran, thus highlighting the need for interprofessional shared decision making [35, 36].

Individuals who need mechanical circulatory support due to advanced heart failure might not be deeply sedated following hemodynamic control and might even resume alertness. Thus, further research is required to understand how to effectively communicate life-or-death care to these patients and work together to create a plan of action. Further study is required to determine the best strategies for resolving conflicts that develop between patients, their families, and medical staff when disclosing advanced heart failure to patients in order to encourage patient involvement in the decision-making procedure despite numerous obstacles. It is also necessary to take into account the challenges associated with moving from acute intensive healthcare to community-based or home-based care. Crucially, transition-related problems must be resolved, particularly palliative care-related ones [37, 38]. This investigation's novel conclusions on the functions that nurses ought to take on in assisting with decisions for severely ill patients include circumstantial analysis and collaborative design of care. On the front lines of healthcare, circumstantial analysis has mostly been employed as a part of team initiatives targeted at protecting patients [39]. Furthermore, it became clear throughout the course of defining the function of circumstantial analysis that nurses work collaboratively as a part of the nursing staff and frequently evaluate the patient and the surrounding environment from a "bird's-eye view." This is due to the fact that nurses in the field operate collaboratively and develop their independence, both of which are essential for them to establish rapport with patients. In interdisciplinary contexts, nurses need to take the lead in independently contributing and implementing shared decision making. Nurses working in critical care take part in the individual's everyday activities once the selected course of action has been put into effect, which implies they connect with the patient, family, and healthcare professionals and jointly develop viewpoints that transcend multiple constraints. This is known as the currently recognized capacity for collaborative design of care. The importance of working with people close to the patient to co-create a preferred way of life is significant, irrespective of the patient's prognosis. For instance, continuing inotropic medication throughout the phase of transition might enhance the patient's standard of life in relation to their health but does not lower risk or increase long-term survival [40].

Thus, it is imperative to engage in collaborative design of care which is not constrained by conventional therapeutic objectives. Patients with critical illnesses who require extensive assistance have an existence outside the hospital that is especially sensitive to the social environment. In contrast to individualized, independent decision-making, shared decision making is now seen through the framework of interpersonal autonomy [41]. Interpersonal autonomy, a new concept in bioethics, plays a critical role in ensuring that patients are empowered, respected, and actively involved in decisions about their care, especially in the context of shared decision-making among patients with advanced heart failure [42]. Unlike the traditional paternalistic model where healthcare professionals make decisions on behalf of the patient, interpersonal autonomy acknowledges the importance of the patient's values, preferences, and relationships in the decision-making process [42]. Interpersonal autonomy recognizes that patients are embedded within social networks, including family members, caregivers, and healthcare professionals. These relationships influence and shape patients' values, beliefs, and decision-making

preferences. Therefore, it's essential for healthcare providers, including nurses, to adopt a collaborative approach that acknowledges and respects these relational dynamics [42]. This concept is in line with the findings of our study, and therefore further research could be beneficial to fully elaborate its formal application through workforce development and training. In the course of their regular professional work, nurses deal with troubled families and patients who are at risk. As such, they can broaden the notion of interpersonal autonomy in terms of practical skills [43]. Our research's findings could advance knowledge on interpersonal autonomy. Our results highlight the importance of nurses in shared decision making and offer insights to address potential problems that may arise when individuals who have advanced heart failure engage in shared decision making. For instance, as this research shows, critical care nurses are able to recognize issues with decision-making and provide assistance in order to help patients with advanced heart failure with some of the challenges they may encounter. Moreover, leveraging decision-support positions within the nursing staff can enhance the standard of assistance in decision-making. It is imperative that the subtleties of shared decision making and the manner in which decisions are made be further clarified from the standpoint of the client and relatives, especially in the context of the interpersonal study of the decision-making process itself [44]. Examining the idea of inter-professional shared decision making, in which a range of health care providers participate in intricate and challenging decision-making, is also essential. This involves taking into account the extent of assistance with decisions and developing arguments for it using clinical results.

Limitations

The inclusion of nurses only from tertiary hospitals in Beirut, which is the capital in Lebanon, hinders the transferability of the study findings. The findings may be influenced by the centralism in the distribution of resources to the different parts of the healthcare system in Lebanon, which pose various constraints on access to healthcare for patients and on the roles of nurses. Thus, it's possible that the study's findings cannot be applied to other regions of Lebanon or different countries. Nonetheless, a number of the themes found in the present research indicated shared challenges are represented in the international research on patients with advanced heart failure and their decision-making.

Conclusion

In summary, the findings of this qualitative study illuminate the multifaceted challenges confronting patients with severe heart failure when they engage in shared decision-making (SDM) about critical care related treatment decisions. The identified challenges not only underscore the inherent complexities in navigating advanced medical care but also underscore the critically important role of the healthcare team, including critical care nurses, in facilitating informed and patient-centered decision-making.

Recommendations

Now it is important for critical care nurses to appreciate the complex nature of these challenges and to engage the nursing team in addressing them. Through collaboration, nurses are able to bring their

multiple expertise together to ensure they provide decision support that is comprehensive and responsive to the needs and worldview of the patient on an individual basis. Collaboration also includes effective communication and coordination with the broader interprofessional healthcare team. Another recommendation suggests critical care nurses are well positioned to lead a focus on patient values and the search for meaning as important drivers of IP-SDM in advanced heart failure. Incorporating these imperative components into the decision making process brings the opportunity for treatment options to be more closely aligned with the patient's objectives, preferences and priorities. Practically, the findings of this research could serve as a draft for developing interprofessional training programs that aim at enhancing the dynamics between healthcare professionals in shared decision making contexts, as well as clarify the various roles and responsibilities of each team member. These training programs could enhance the quality of care rendered to this patient population and further enhance the decision making process for them in critical situations. This also entails policy changes that should be advocated for by nurse leaders in order to empower and situate critical care nurses as influential and valuable members at the heart of the interdisciplinary team within the shared decision making process. As a future direction, research would be well placed to look at longitudinal studies focused on the longer term outcomes of IP-SDM decisions. Equally important is research that includes a diverse range of patient populations, considering things like diagnosis, age, socioeconomic status, cultural backgrounds, health numeracy and literacy.

Declarations

Ethics approval and consent to participate

The work described has been carried out in accordance with The Code of Ethics of the World Medical Association (Declaration of Helsinki) for experiments involving humans; Uniform Requirements for manuscripts submitted to Biomedical journals. The Institutional Review Board was acquired from Rayak Hospital (IRB number: ECO-R-219). Informed consent to participate was obtained from all participants.

Consent for publication

Not applicable.

Competing interests

The authors declare that they have no competing interests.

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Author Contribution

DA did the conceptualization, methodology, investigation, formal analysis, data curation, writing, review & editing, project administration, and supervision of the manuscript.

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Data Availability

The datasets generated and/or analysed during the current study are not publicly available due privacy concerns but are available from the corresponding author on reasonable request

Patient consent statement

Not applicable.

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